



**DOCUMENTATION REQUEST FOR PSYCHOLOGICAL CONDITION**

I, \_\_\_\_\_, am requesting accommodations due to my medical condition/disability with respect to my employment at Delaware Technical & Community College. The accommodations will be based on the nature of the disability (defined as an impairment that substantially limits one or more major life activities) as it impacts my ability to perform the essential functions as set forth on the attached job description. Please provide the information requested by mail at the following address: \_\_\_\_\_

\_\_\_\_\_                                      \_\_\_\_\_                                      \_\_\_\_\_  
Date    Employee Signature    Date of Birth

Primary Diagnosis \_\_\_\_\_

Secondary Diagnosis \_\_\_\_\_

Date of Onset \_\_\_\_\_                                      Date of Last Visit \_\_\_\_\_

Please describe the functional limitations/behavioral manifestations that impact on the person's ability to conduct major life activities.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe any limitations on the person's cognitive abilities due to the medical condition.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe any limitations on the employee's ability to perform the principal accountabilities in the attached position description as a result of the medical condition/disability.

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Please identify any medication that has been prescribed for the medical condition/disability for which an accommodation is sought and describe any side effects that may interfere with the employee's ability to perform the job functions attached hereto.

Medication	Effects
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If this is a chronic condition, please describe frequency of episodes, if known.

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What is the expected progression or stability of the diagnosis?

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What strategies have previously been employed to manage the medical condition/disability?

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What workplace accommodations/auxiliary aids are you recommending?

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What alternative accommodations/auxiliary aids are available to manage the medical condition/disability?

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Please include any other information which you believe would be useful in determining appropriate assistance for this person in the context of the attached job description.

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If you would prefer to do so, you may provide this information in narrative form on your office letterhead.

*(Please print)*

Provider name: \_\_\_\_\_ Title: \_\_\_\_\_ License #: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.